

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155278		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 07/14/2011	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-BLOOMINGTON				STREET ADDRESS, CITY, STATE, ZIP CODE 155 EAST BURKS DR BLOOMINGTON, IN47401			
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F0000	<p>This visit was for the investigation of Complaint IN00092998.</p> <p>Complaint IN00092998 substantiated. Federal/State deficiencies related to the allegations are cited at F-333 and F-514.</p> <p>Survey Dates: July 13 and 14, 2011</p> <p>Facility number: 000177 Provider number: 155278 AIM number: 100289860</p> <p>Survey team: Sharon Whiteman RN</p> <p>Census bed type: SNF/NF: 127 Total: 127</p> <p>Census payor type: Medicare: 08 Medicaid: 101 Other: 18 Total: 127</p> <p>Sample: 03</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 7/18/11</p>			F0000	<p>Submission of this Response and Plan of Correction is not a legal admission that A deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under State and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in the Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. Facility respectfully requests a desk review of the Plan of Correction due to the documentation allegations.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F0333 SS=D	<p>Cathy Emswiler RN</p> <p>The facility must ensure that residents are free of any significant medication errors. Based on record review and interview, the facility failed to ensure 1 of 3 residents (Resident #A) reviewed for drug allergies in a sample of 3 did not receive medication which was listed in the resident's clinical record as medication which the resident was allergic to.</p> <p>Findings Include:</p> <p>Review of Resident #A's closed clinical record on 07/13/11 at 11:15 p.m. indicated the following:</p> <p>The inside front cover of the resident's clinical record was observed to have a red alert tag which indicated the resident was allergic to Hydralazine (blood pressure medication), Quinidine (medication often used to treat irregular heart rhythms), and Codeine (pain medication)</p> <p>A hospital discharge medication list, dated 06/10/11, indicated the resident was also allergic to Clonidine (blood pressure medication).</p>			F0333	<p>F 0333</p> <p>Resident A is not a current resident of the facility. The hospital history and physical dated 6/10/11 indicated under allergies: Hydralazine (headache) and note that patient is currently on Hydralazine without problem. Clonidine (unknown reaction) suspect there is no reaction. The hospital history and physical did not indicate the patient had an allergy to Quinidine or Codiene. The hospital medication discharge list indicated allergies: Codiene and Clonidine. The facility Nurse received an order from the physician to administer Clonidine 0.1 mg. The pharmacy was contacted regarding the administration of Clonidine. The dose given to the resident is the lowest possible dose of the medication. The medication is the drug of choice with acute hypertension. Regarding administration of the medication to a renal patient. Most all medications on the market are to be used cautiously in patients with renal insufficiency.</p> <p>On July 13, 2011, when notified by the surveyor of the transcription error</p>		07/21/2011

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	<p>A hospital "History and Physical" report, dated 06/07/11, listed Clonidine as a medication which Resident #A was allergic to.</p> <p>An "Admission" "Clinical Health Status" report indicated Resident #A was admitted to the Long Term Care facility from a local hospital on 06/10/11. The "Admission" report listed Clonidine as a medication which Resident #A was allergic to.</p> <p>A 2010 Nursing Spectrum Drug Handbook indicated Clonidine was to be used with caution in patients with diagnosis of Chronic Renal Insufficiency.</p> <p>Resident #A had diagnoses, which included but were not limited to, End Stage Renal Disease, high blood pressure, Tubular Necrosis, Anxiety, and chronic obstructive pulmonary disease.</p> <p>A nursing note with a "Created Date" of 06/21/11 at 7:44 a.m. indicated, "resident (Resident #A) c/o (complained of) not 'feeling well.' Initially her Bp (blood pressure) was 233/126 and O2 (oxygen level) was 91% on 2L (Liters of oxygen). Called MD and received one time order for clonidine (sic) 0.1 mg (milligram). Bp then went down to 184/94, p (pulse) was</p>				<p>of the allergies; the facility immediately audited all resident charts to ensure that all allergies were current and the red allergy sticker on the front of the chart, the computer generated allergy listings, and the last history and physical all listed the same diagnosis. No other discrepancies were found.</p> <p>All Licensed Nurses were in-serviced on July 21, 2011 regarding the importance of or correctly inputting resident allergies into the computer at the time of admission. The Licensed Nurses were also in-serviced to ensure the red allergy sticker on the front of the chart matches the computer generated list and history and physical from the hospital.</p> <p>The Unit managers (Monday-Friday) and the Weekend RN (Saturday-Sunday) will audit/review all new admissions to ensure that the allergy information was transcribed properly into the facility medical record system from the history and physical and discharge medication list received from the hospital as well as the allergy sticker located on the chart.</p> <p>The DNS/ADNS will review the audits completed by the Unit manager/Weekend RN to ensure all new admissions were reviewed regarding the allergy information and compile results for review by the QA</p>		

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	<p>96, r (respirations) 22. O2 went down to 49. Gave PRN (as needed) albuterol (sic) (breathing treatment), (sic) No change in sats (oxygen saturation), received order to send her to the ED (Emergency Department). attempted (sic) to call family several times. left (sic) message with daughter."</p> <p>Documentation provided by the DON on 07/14/11 at 11:40 a.m. indicated, "Investigation" (of Resident #A's decline and transfer to hospital) on 06/21/11 indicated, "Asked if she (LPN #1) checked allergies - said yes - Clonidine was not a listed allergy. States right before 6 A (6:00 a.m.) - she would say 5 minutes till she went in room and (Resident #A) c/o not feeling well - she took her vital signs. B/p (blood pressure) was elevated. Called (Doctor's name) he said to give her Clonidine and send to ER if didn't help. When she went back to room and took V/S (vital signs) her (Resident A's) O2 sat (oxygen saturation) had dropped to 49%. She (LPN #1) had a CNA stay with her (Resident #A) - She (LPN #1) went out and called 911 and (physician) - She then went back and gave her (Resident #A) Clonidine and Albuterol (breathing treatment). States ambulance left with her (Resident #A) at 6:40 a.m....Clonidine order was written at 6:21 A (a.m.) - out of EDK at 6:30 AM."</p>				<p>committee.</p> <p>The Quality Assurance committee will review the results of the allergy admission audits monthly for a minimum of 3 months and determine if further audits are needed.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	<p>Interview of the DON on 07/14/11 at 11:00 a.m. indicated upon questioning LPN #1 she was told that the LPN had read the allergies to the physician from the allergy alert tag on the front cover of the chart and Clonidine was not listed on the tag.</p> <p>A copy of a chest X-Ray, dated 06/07/11, indicated, "...There are findings consistent with worsening pulmonary vascular congestion since 5/21/11.</p> <p>Review of hospital records on 07/13/11 at 3:40 p.m. indicated Resident #A arrived by ambulance to the Emergency Department on 06/21/11 at 7:07 a.m.</p> <p>Documentation titled "Emergency Department Chart," dated 06/21/11 indicated [Resident #A] had diagnoses of Chronic Renal Failure, laboratory evidence of respiratory failure, and altered mental status.</p> <p>A "Coroner Case Report," dated 06/21/11 indicated Resident #A's cause of death was "Respiratory arrest" and manner of death was "Natural."</p> <p>This Federal/State deficiency relates to Complaint IN00092998.</p>						

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F0514 SS=D	<p>3.1-25(b)(9)</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to ensure 1 of 3 residents (Resident #A) reviewed for drug allergies in a sample of 3, had a clinical record which was accurately documented with the resident's allergies listed on the facility form designated as the place to look to identify the resident's allergies.</p> <p>Findings Include:</p> <p>Review of Resident #A's closed clinical record on 07/13/11 at 11:15 p.m. indicated the following:</p> <p>The inside front cover of the resident's clinical record was observed to have a red</p>			F0514	<p>F0514Resident A is not a current resident of the facility. The hospital history and physical dated 6/10/11 indicated under allergies: Hydralazine (headache) and note that patient is currently on Hydralazine without problem. Clonidine (unknown reaction) suspect there is no reaction. The hospital history and physical did not indicate the patient had an allergy to Quinidine or Codiene. The hospital medication discharge list indicated allergies: Codiene and Clonidine. The facility Nurse received an order from the physician to administer Clonidine 0.1 mg. The pharmacy was contacted regarding the administration of Clonidine. The</p>		07/25/2011

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	<p>alert tag which indicated the resident was allergic to Hydralazine (blood pressure medication), Quinidine (medication often used to treat irregular heart rhythms), and Codeine (pain medication)</p> <p>A hospital discharge medication list, dated 06/10/11, indicated the resident was also allergic to Clonidine (blood pressure medication).</p> <p>A hospital "History and Physical" report, dated 06/07/11, listed Clonidine as a medication which Resident #A was allergic to.</p> <p>An "Admission" "Clinical Health Status" report indicated Resident #A was admitted to the Long Term Care facility from a local hospital on 06/10/11. The "Admission" report listed Clonidine as a medication which Resident #A was allergic to.</p> <p>A 2010 Nursing Spectrum Drug Handbook indicated Clonidine was to be used with caution in patients with diagnosis of Chronic Renal Insufficiency.</p> <p>Resident #A had diagnoses, which included but were not limited to, End Stage Renal Disease, high blood pressure, Tubular Necrosis, Anxiety, and chronic obstructive pulmonary disease.</p>				<p>dose given to the resident is the lowest possible dose of the medication. The medication is the drug of choice with acute hypertension. Regarding administration of the medication to a renal patient. Most all medications on the market are to be used cautiously in patients with renal insufficiency. On July 13, 2011, when notified by the surveyor of the transcription error of the allergies; the facility immediately audited all resident charts to ensure that all allergies were current and the red allergy sticker on the front of the chart, the computer generated allergy listings, and the last history and physical all listed the same diagnosis. No other discrepancies were found. All Licensed Nurses were in-serviced on July 21, 2011 regarding the importance of or correctly inputting resident allergies into the computer at the time of admission. The Licensed Nurses were also in-serviced to ensure the red allergy sticker on the front of the chart matches the computer generated list and history and physical from the hospital. The Unit managers (Monday-Friday) and the Weekend RN (Saturday-Sunday) will audit/review all new admissions to ensure that the allergy information was transcribed properly into the facility medical record system from the history and physical and discharge medication list received</p>		

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	<p>A nursing note with a "Created Date" of 06/21/11 at 7:44 a.m. indicated, "resident (Resident #A) c/o (complained of) not 'feeling well.' Initially her Bp (blood pressure) was 233/126 and O2 (oxygen level was 91% on 2L (Liters of oxygen). Called MD and received one time order for clonidine (sic) 0.1 mg (milligram). Bp then went down to 184/94, p (pulse) was 96, r (respirations) 22. O2 went down to 49. Gave PRN (as needed) albuterol (sic) (breathing treatment), (sic) No change in sats (oxygen saturation), received order to send her to the ED (Emergency Department). attempted (sic) to call family several times. left (sic) message with daughter."</p> <p>Documentation provided by the DON on 07/14/11 at 11:40 a.m. indicated, "Investigation" (of Resident #A's decline and transfer to hospital) on 06/21/11 indicated, "Asked if she (LPN #1) checked allergies - said yes - Clonidine was not a listed allergy. States right before 6 A (6:00 a.m.) - she would say 5 minutes till she went in room and (Resident #A) c/o not feeling well - she took her vital signs. B/p (blood pressure) was elevated. Called (Doctor's name) he said to give her Clonidine and send to ER if didn't help. When she went back to room and took V/S (vital signs) her</p>				<p>from the hospital as well as the allergy sticker located on the chart. The DNS/ADNS will review the audits completed by the Unit manager/Weekend RN to ensure all new admissions were reviewed regarding the allergy information and compile results for review by the QA committee. The Quality Assurance committee will review the results of the allergy admission audits monthly for a minimum of 3 months and determine if further audits are needed.</p>		

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	<p>(Resident A's) O2 sat (oxygen saturation) had dropped to 49%. She (LPN #1) had a CNA stay with her (Resident #A) - She (LPN #1) went out and called 911 and (physician) - She then went back and gave her (Resident #A) Clonidine and Albuterol (breathing treatment). States ambulance left with her (Resident #A) at 6:40 a.m....Clonidine order was written at 6:21 A (a.m.) - out of EDK at 6:30 AM."</p> <p>Interview of the DON on 07/14/11 at 11:00 a.m. indicated upon questioning LPN #1 she was told that the LPN had read the allergies to the physician from the allergy alert tag on the front cover of the chart and Clonidine was not included on the alert tag as being an allergic medication..</p> <p>This Federal/State deficiency relates to Complaint IN00092998.</p> <p>3.1-50(a)(1)</p>						